Health Care Provider: Please fax to Language of Love Child Care Center at 866-330-6122. Thank you!

HEALTH CARE SUMMARY

MUST BE COMPLETED BY HEALTH CARE SOURCE

Date of Enrollment: _____

NAME OF CHILD _____ Birth Date _____

ADDRESS _____ Telephone _____

PARENT(S) OR GUARDIAN _____

Date of last physical examination _____ How long have you been seeing this child? _____

How frequently do you see this child when he/she is not ill? _____

Does this child have any allergies (including allergies to medications)? _____

Is a modified diet necessary? _____

Is any condition present that might result in an emergency? _____

_____

What is the status of the child's. . . Vision _____

Hearing _____

Speech _____

Please list below the important health problems

Important Health Problems	Followed By You	Followed By Other Med Source (Name)	Requires Special Attention at Center

Other information helpful to the child care program _____

_____

_____

Phone _____

Signature of Health Source _____ Address _____

Date _____ _____

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